

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019418

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

393  
FILED MAY 29 1963

Primary Registration District No.

1002

Registrar's No.

2743

STATE FILE NUMBER

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>14 yrs</u>	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Guardian Angel Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>A</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1963</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cardiff, Wales</u>	
13a. FATHER'S NAME <u>William Davis</u>		13b. MOTHER'S MAIDEN NAME <u>unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. INFORMANT <u>Henry Gashiel No. Ridge, Calif.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO (b) <u>Encephalomalacia</u> DUE TO (c) <u>Cerebral arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>3 hrs</u> <u>10 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Sanitary</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II, of item 18.)	
20c. TIME OF INJURY Hour <u>11</u> s.m. <u>45</u> Month, Day, Year <u>5-10-63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>1961</u> to <u>5-10-63</u> and last saw him alive on <u>5-10-63</u> Death occurred at <u>11 45</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>James M. Boone MD</u> (Degree or title)	
22b. ADDRESS <u>2025 Scott St KC</u>		22c. DATE SIGNED <u>5-10-63</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-13-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Florence Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Florence, Kansas</u>
24. FUNERAL DIRECTOR <u>Assanteno Bros</u>	ADDRESS <u>KC Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-11-63</u>	26. REGISTRAR'S SIGNATURE <u>Arthur Long</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Dr. Boone  
2025 Swift

2000  
180

0  
4  
0

6-28

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Robert S. Sautter*

Licensed Embalmer No. 4554

P. O. Address KC MO.

Note: The above-MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.